STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010409	A. BUILDING: _____ B. WING _____	R 08/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KEYSTONE WOODS	2335 N MADISON AVE ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) for the State Residential Licensure Survey completed on 7/15/15. Survey Dates: August 21, 2015 Facility Number: 010409 Provider Number: 010409 AIM Number: N/A Census Bed Type: Residential: 54 Total: 54 Census Payor Type: Other: 54 Total: 54 Sample: 6 Keystone Woods was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Survey.	{R 000}		